VIII. Revisions

The plan shall be revised as operating experience data are developed and the need for changes is necessary in accordance with modifications in the Code of Federal Regulations (1998).

IX. Payment in Full

Participation in the Program shall be limited to hospitals of service which accept as payment in full for covered services the amount paid in accordance with the Florida Title XIX Outpatient Hospital Reimbursement Plan.

X. Definitions

A. Acceptable Cost Report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.

B. AHCA - Agency for Health Care Administration, also known as the Agency.

C. Allowable Costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with generally accepted accounting principles except as modified by the Principles of Reimbursement for Provider Costs, as defined in HCFA PUB. 15-1 as incorporated by reference in 59G-6.010 F.A.C., and as further defined in the Florida Title XIX Outpatient Hospital Reimbursement Plan.

D. Community Hospital Education Program (CHEP) hospitals – Hospitals that participate in a program established by the Community Hospital Education Act (381.0403, F.S.) and administered by the Florida Board of Regents. CHEP hospitals offer continuing medical education programs for interns and residents established on a statewide basis. The CHEP program provides financial support for interns and residents based on policies recommended and approved by the Community Hospital Education Council and the Board of Regents.

E. Cost Reporting Year - A 12-month period of operation based upon the provider's accounting year.

F. Eligible Medicaid Recipient - "Recipient" or "Medicaid recipient" means any individual whom the department, or the Social Security Administration on behalf of the agency, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which the department may make payments under the Medicaid program and is enrolled in the Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

G. Florida Medicaid Log - A schedule to be maintained by a hospital listing each Medicaid patient's recipient number, dates of admission and discharge, and the charges and payments for services and goods received from the hospital's revenue centers.

H. Florida Price Level Index - A spatial index which measures differences from county to county in the cost of purchasing a specified market basket of items at a particular point in time. The items in the market basket range from various food products to hospital lab fees, and are grouped into the components of Food, Housing, Apparel, Transportation, and Health, Recreation and Personal Services. A county index for each of the five components is developed bi-annually by the Florida Executive Office of the Governor. County indices are population weighted to average 100 percent. An index of 1.1265 for a given county means that the basket of goods in that county costs 12.65 percent more than the State average. Changes to the methodology utilized in the development of the FPLI will constitute changes in this plan and will require a formal plan amendment.

I. General hospital – A hospital in this state that is not classified as a specialized hospital.

J. HHS - Department of Health and Human Services

K. HCFA PUB. 15-1 - Health Insurance Manual No. 15, also known as the Provider Reimbursement Manual, as incorporated by reference in Rule 59G-6.010, F.A.C..

L. Medicaid Outpatient Charges - Usual and customary charges for outpatient services rendered to Medicaid patients excluding charges for laboratory and pathology services. These charges shall be the allowable charges as reconciled with the hospital Medicaid log and found on the Medicaid paid claims report.

M. Medicaid Outpatient Occasions of Service - The number of distinct revenue center code line items listed on a valid claim that a hospital has submitted to the fiscal agent, excluding laboratory and pathology revenue center code line items, and that have been paid by the fiscal agent, which represent covered Medicaid outpatient services.

N. Medicaid Outpatient Variable Costs - Allowable operating costs excluding laboratory and pathology costs less return on equity as apportioned to Medicaid by cost finding methods in the HCFA 2552 cost report.

O. Non-Covered Services - Those goods and services which are not medically necessary for the care and treatment of outpatients as defined in HCFA PUB 15.1 as incorporated by reference in Rule 59G-6.010, F.A.C.

P. Rate Semester - January 1 through June 30 of a given year, or July 1 through December 31 of a given year.

Q. Reimbursement Ceiling - The upper limit for Medicaid Outpatient Variable Cost rate reimbursement for an individual hospital.

R. Reimbursement Ceiling Period - January 1 through June 30 of a given year or July 1 through December 31, of a given year.

S. Rural Hospital - An acute care hospital licensed under Florida Statutes, Chapter 395 with 85 licensed beds or less, which has an emergency room and is located in an area defined as rural by the United States Census, and which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile; or
2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county; or
3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.

T. Specialized Hospital - A licensed hospital primarily devoted to TB, psychiatric care, pediatric, eye, or cardiac care and treatment; or a licensed hospital that has ten or more residency training programs.

U. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395xx).

V. Title XIX - Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396p).

W. Total Outpatient Charges - Total patient revenues assessed for all outpatient services excluding charges for laboratory and pathology.

APPENDIX A TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

OUTPATIENT REVENUE CENTER CODES

CODE	DESCRIPTION
250	Pharmacy/General
251	Pharmacy/Generic
252	Pharmacy/NonGeneric
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
258	Pharmacy/IV Solutions
261	Infusion Pump
262	IV Therapy/Pharmacy Services
264	IV Therapy/Supplies
271	Medical Surgical- Nonsterile supplies
272	Medical/Surgical - Sterile Supplies
273	Burn Pressure Garment
274	Cochlear Implant Handling (ages 2-20 only)
275	Pacemaker
276	Intraocular Lens
278	Subdermal Contraceptive Implant
279	Burn Pressure Garment Fitting
300	Laboratory/General
301	Laboratory/Chemistry
302	Laboratory/Immunology
303	Laboratory/Renal Patient (Home)
304	Laboratory/Non-Routine Dialysis
305	Laboratory/Hematology
306	Laboratory/Bacteriology and Microbiology
307	Laboratory/Urology
310	Pathological Laboratory/General
311	Pathological Laboratory/Cytology
312	Pathological Laboratory/Histology
314	Pathological Laboratory/Biopsy
320	Diagnostic Radiology/General
321	Diagnostic Radiology/Angiocardiography
322	Diagnostic Radiology/Arthrography
323	Diagnostic Radiology/Arteriography
324	Diagnostic Radiology/Chest
330	Therapeutic Radiology/General
331	Therapeutic Radiology/Injected
332	Therapeutic Radiology/Oral
333	Therapeutic Radiology/Radiation Therapy
335	Therapeutic Radiology/Chemotherapy - IV
340	Nuclear Medicine/General
341	Nuclear Medicine/Diagnostic
342	Nuclear Medicine/Therapeutic
350	Computed Tomographic (CT) Scan/General
351	Computed Tomographic (CT) Scan/Head
352	Computed Tomographic (CT) Scan/Body

360 Operating Room Services/General
361 Operating Room Services/Minor Surgery
370 Anesthesia/General
371 Anesthesia Incident to Radiology
372 Anesthesia Incident to Other Diagnostic Services
380 Blood/General
381 Blood/Packed Red Cells
382 Blood/Whole
383 Blood/Plasma
384 Blood/Platelets
385 Blood/Leucocytes
386 Blood/Other Components
387 Blood/Other Derivatives
390 Blood Storage and Processing/General
391 Blood Storage and Processing/Administration
400 Imaging Services/General
401 Imaging Services/Mammography
402 Imaging Services/Ultrasound
403 Screening Mammography
404 Positron Emission Tomography
410 Respiratory Services/General (All Ages)
412 Respiratory Services/Inhalation (All Ages)
413 Respiratory Services/Hyperbaric Oxygen Therapy (All Ages)
421 Physical Therapy/Visit Charge (All Ages)
424 Physical Therapy/Evaluation or Re-evaluation(All Ages)
Note: Effective 1/1/99
431 Occupational Therapy/Visit Charge (Under 21 only)
434 Occupation Therapy/Evaluation or Re-evaluation (Under 21)
Note: Effective 1/1/99
441 Speech-Language Pathology/Visit Charge (Under 21 only)
444 Speech-Language Pathology/Evaluation or Re-evaluation Under 21) Note: Effective 1/1/99
450 Emergency Room/General
451 EMTALA Emergency Medical Screening Services
(Effective 7/1/96)
- EMTALA: Emergency Medical Treatment and Active Labor Act
- Use 451 when the recipient needs no ER care beyond the EMTALA emergency medical screening
- Code W1700 must be used with code 451; example 451(W1700)

Note: No MediPass authorization required

460 Pulmonary Function/General
471 Audiology/Diagnostic
472 Audiology/Treatment
480 Cardiology/General
481 Cardiology/Cardiac Cath Laboratory
482 Cardiology/Stress Test
483 Cardiology/Echocardiology
490 Ambulatory Surgical Care
Note: Use code 490 when billing for services rendered in a hospital-owned ambulatory surgical center
510 Clinic/General

513 Psychiatric Clinic
Note: Use code 513, pychiatric clinic, with code 914, psychiatric individual therapy services, or with 918, psychiatric testing, when either of these codes is appropriate and applicable.
610 MRI Diagnostic/General
611 MRI Diagnostic/Brain
612 MRI Diagnostic/Spine
621 Supplies Incident to Radiology
622 DressingsSupplies Incident to Other Diagnostic Services
623 Surgical Dressings
637 Self-Administered Drugs (Effective 10/1/97)
Note: Use code 637 exclusively to bill self-administered drugs not covered by Medicare for dually-eligible Medicare and Medicaid recipients. Code 637 must only be billed with the Total Charge 001 revenue code. Payment will be made for 637 only.
700 Cast Room/General
710 Recovery Room/General
721 Labor - Delivery Room/Labor
722 Labor - Delivery Room/Delivery
730 EKG - ECG/General
731 EKG - ECG/Holter Monitor
732 Telemetry
740 EEG/General
750 Gastro-Intestinal Services/General
761 Treatment Room
762 Observation Room
790 Lithotripsy/General
821 Hemodialysis Outpatient/Composite
831 Peritoneal Dialysis Outpatient/Composite Rate
880 Miscellaneous Dialysis/General
901 Psychiatric/Psychological - Electroshock Treatment
914 Psychiatric/Psychological - Clinic Visit/Individual Therapy
918 Psychiatric/Testing (Effective 1/1/99)
Note: Bill 513, psychiatric clinic, with this service, 918.
921 Other Diagnostic Services/Peripheral Vascular Lab
922 Other Diagnostic Services/Electromyelgram
924 Other Diagnostic Services/Allergy Test
943 Other Therapeutic Services/Cardiac Rehabilitation
944 Other Therapeutic Services/Drug Rehabilitation
945 Other Therapeutic Services/Alcohol Rehabilitation

APPENDIX B TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN ADJUSTMENTS TO ALLOWABLE MEDICAID VARIABLE COSTS

An example of the technique to be utilized to adjust allowable Medicaid variable costs for inflation in the computation of the reimbursement limits is detailed below. Assume the following DRI Quarterly Indices:

	1978	1979	1980	1981	1982
Q1	213.0	237.7	250.1	278.1	308.0
Q2	217.8	234.5	256.5	285.9	314.9
Q3	222.7	237.9	263.2	294.0	322.0
Q4	227.7	243.8	270.4	301.2	329.3

The elements in the above table represent a weighted composite index based on the following weights and the components:

COMPONENTS	WEIGHTS
Payroll and Professional Fees	55.57%
Employee Benefits	7.28%
Dietary and Cafeteria	3.82%
Fuel and Other Utilities	3.41%
Other	29.92%
	100.00%

Based on the quarterly indices, monthly indices are calculated by averaging pairs of quarterly indices and interpolating between these averages as follows:

QUARTER	INDEX	AVERAGE INDEX	MONTH
1	213.0		
		215.4	MARCH 31
2	217.8		
		220.3	JUNE 30
3	222.7		
		225.2	SEPT. 30
4	227.7		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ (March 31 Index)

$= (220.3/215.4)^{1/3} (215.4)$
$= 217.0$

May 31 Index = (June 30 Index/March 31 Index)$^{2/3}$ (March 31 Index)

$= (220.3/215.4)^{2/3} (215.4)$
$= 218.7$

All other monthly indices can be calculated in a similar fashion. To determine the applicable inflation factor for a given hospital for the first semester of 1981-82 the index for September 30, 1981, the midpoint of the rate semester, is divided by the index for the midpoint of the Provider's Fiscal Year. For example, if a hospital has a fiscal year end of November 30, 1978 then its midpoint is May 31, and the applicable inflation is:

September 1981 Index/May 1978 Index = 297.6/218.7 = 1.3607

Therefore, the hospitals reported variable cost Medicaid rate is multiplied by 1.3607 to obtain the estimated average variable Medicaid rate for the first rate semester of FY 1981-82. Similar calculations utilizing March 31, as the midpoint yield adjustments for the second semester of FY 1981-82.

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